

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814  
(916) 323-4954



September 17, 1986

ALL-COUNTY LETTER NO. 86-91

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: (1) Revised Forms: DFA 285-D (6/86), DFA 377.5 (6/86),  
DFA 440 (4/86)  
(2) Revised Eligibility Worker Form Instructions:  
DFA 285-B (4/86), DFA 285-D (6/86), DFA 377.5 (6/86)  
(3) Other Forms: DFA 285-C (12/83), CA 22 (10/85), CA 72 (10/84)

REFERENCE: ALL-COUNTY LETTER 86-22, DATED MARCH 17, 1986  
ALL-COUNTY LETTER 86-41, DATED MAY 27, 1986

The purpose of this letter is to transmit advance copies of three revised forms, transmit revised eligibility worker instructions for three forms, and to provide the County Welfare Departments (CWDs) with form-related information for all of the following forms:

- DFA 285-B (4/86) Food Stamp Budget Worksheet
- DFA 285-C (12/83) Supplemental Application for Food Stamps - Special Medical Deductions
- DFA 285-D (6/86) Food Stamp Budget Worksheet - Special Medical/Shelter Deductions
- DFA 377.5 (6/86) Food Stamp Household Change Report
- DFA 440 (4/86) Verification of Physical and Mental Disability (Food Stamp Program)
- CA 22 (10/85) Alien Sponsor's Statement of Facts Regarding Income and Resources
- CA 72 (10/84) Alien Sponsor's Monthly Income and Resources Report

Attachment A provides an index to the other attachments. The material in this letter primarily concerns Food Stamp Program related information. However, one AFDC Program related issue concerning the alien sponsor forms is included in Attachment G, "CA 22 (10/85) and CA 72 (10/84), Form-Related Information".

GEN 654 (2/82)

### Revised Forms

The three revised forms included in this letter are the DFA 285-D (6/86) (Attachment D-1) and the English and Spanish language versions of the DFA 377.5 (6/86) (Attachments E-1 and E2) and the DFA 440 (4/86) (Attachments F-1 and F-2). Those counties printing their own stock may contact Elizabeth Allred at 916-323-4954 or ATSS 8-473-4954 for a camera ready copy. NOTE: (1) The front page only of the DFA 285-D (6/86) was revised. (2) The DFA 440(SP)(4/86) is a new form. This form is for local reproduction by the county because the state will not reproduce or stock the DFA 377.5(SP)(6/86).

### Revised Form Instructions

Revised form instructions for the eligibility worker are included for the DFA 285-B (4/86) (Attachment B-2), the DFA 285-D (6/86) (Attachment D-2) and the DFA 377.5 (4/86) (Attachment E-3).

### Other Attachments

In addition to the attached copies of the revised forms and the revised form instructions, this letter provides an attachment entitled "Form-Related Information" for each of the seven forms addressed in this letter.

As applicable, these attachments provide the counties with:

1. Information to supplement both ACL 86-22, dated March 17, 1986, concerning the May 1, 1986 deduction and resource regulation changes, and ACL 86-41, dated May 27, 1986, concerning the June 1, 1986 farm offset regulations.
2. A discussion of current changes to the revised forms and to the revised form instructions.
3. An outline of pending revisions of forms.

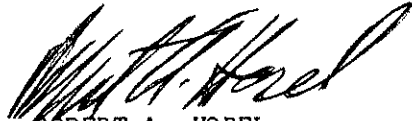
NOTE: The DFA 285-C (12/83) and the DFA 440 (4/86) are the only forms addressed in this letter with pending revisions. In view of these pending changes, the counties may route any suggestions for other changes to the AFDC and Food Stamp Policy Implementation Bureau, Department of Social Services, 744 P Street, M.S. 16-31, Sacramento, CA 95814.

4. Procedures for ordering state reproduced stock of the revised forms from the DSS warehouse.
5. Procedures for obtaining copies of the foreign language versions of the revised forms.

6. Various issues concerning the implementation of the three revised forms.

NOTE: No specific implementation dates are provided for either the DFA 377.5 (6/86) or the DFA 440 (4/86) as the counties are advised to implement these revised forms as outlined below in Attachments E and F.

If you have any questions regarding this letter or the attachments, please contact Elizabeth Allred, AFDC/Food Stamp Compliance Unit at (916) 323-4954 or ATSS 473-4954.



ROBERT A. HOREL  
Deputy Director

cc: CWDA

## Attachment A

## Index to Attachments

Form Number and Revision Date	Description	Attachment
DFA 285-R(4/86)	Form-Related Information	R
	Copy of DFA 285-R(4/86)	R-1
	Revised Eligibility Worker Instructions	R-2
DFA 285-C(12/83)	Form-Related Information	C
DFA 285-D(6/86)	Form-Related Information	D
	Advance copy of DFA 285-D(6/86)	D-1
	Revised Form Instructions for the Eligibility Worker	D-2
DFA 377.5(6/86)	Form-Related Information	E
	Advance copy of DFA 377.5(6/86)	E-1
	Advance copy of DFA 377.5(SP)(6/86)	E-2
	Revised Form Instructions for the Eligibility Worker	E-3
DFA 440(4/86)	Form-Related Information	F
	Advance copy of DFA 440(4/86)	F-1
	Advance copy of DFA 440(SP)(4/86)	F-2
CA 22(10/85) and CA 72(10/84)	Form-Related Information	G

Form-Related Information

Revision of Form and Outline of Major Changes

Attachment B-1 provides a copy of the DFA 285-B(4/86). An advance copy of the DFA 285-B(4/86) was provided in ACL 86-22, which also provided an outline of the major changes to the form.

Form Instructions for the Eligibility Worker

Attachment B-2 provides revised eligibility worker instructions for the DFA 285-B(4/86), which contains information relating to both the May 1, 1986 deduction and resource regulation changes and the June 1, 1986 farm self-employment offset regulations previously addressed in ACL 86-22 and ACL 86-41 respectively. An attachment to these instructions, the "DFA 285-B(4/86) Appendix - Offsetting A Farm Self-Employment Loss", provides the steps for computing the self-employment loss and performing the gross and net income eligibility tests and benefit computation for those households containing a self-employed farmer.

Implementation and Ordering of Stock

Information on implementation and ordering of forms was previously outlined in ACL 86-22 and ACL 86-41.

Attachment B-1

# FOOD STAMP BUDGET WORKSHEET

CASE NAME		CASE NUMBER	COMPANION CASE REFERENCE	CLASSIFICATION <input type="checkbox"/> NA <input type="checkbox"/> PA <input type="checkbox"/> MIXED
CERTIFICATION PERIOD FROM	THROUGH	ISSUANCE MONTH	ISSUANCE MONTH	DOCUMENTATION
<b>PART 1 - GROSS INCOME ELIGIBILITY</b>				
<b>A. NONEXEMPT GROSS EARNED INCOME</b>				
1. Gross Salary, Wages		\$ _____	\$ _____	
2. Self-Employment		_____	_____	
3. Training Allowance		_____	_____	
4. Total Gross Earned Income (A1 + A2 + A3)		\$ _____	\$ _____	
<b>B. NONEXEMPT GROSS UNEARNED INCOME</b>				
1. Cash Aid		\$ _____	\$ _____	
2. Social Security, UIB, DIB, Pensions		_____	_____	
3. Child/Spousal Support		_____	_____	
4. Scholarships, Grants, Loans		_____	_____	
5. Other		_____	_____	
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)		\$ _____	\$ _____	
<b>C. GROSS INCOME TEST</b>				
1. Household Size		_____	_____	
2. Maximum Gross Income Allowed (from Table)		\$ _____	\$ _____	
3. Total Gross Monthly Income (A4 + B6)		\$ _____	\$ _____	
4. Gross Income Eligible? (Is C3 less than or equal to C2?)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PART 2 - NET INCOME ELIGIBILITY</b>		<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective	<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective	
<b>D. INCOME (For Prospective Budgets Only)</b>				
1. Adjusted Gross Earned Income (80% of A4)		\$ _____	\$ _____	
2. Total Nonexempt Gross Income (B6 + D1)		\$ _____	\$ _____	
<b>E. NONEXEMPT GROSS EARNED INCOME (For Retrospective Budgets Only)</b>				
1. Gross Salary, Wages		\$ _____	\$ _____	
2. Self-Employment		_____	_____	
3. Training Allowance		_____	_____	
4. Total Gross Earned Income (E1 + E2 + E3)		\$ _____	\$ _____	
5. Adjusted Gross Earned Income (80% of E4)		\$ _____	\$ _____	
<b>F. NONEXEMPT GROSS UNEARNED INCOME (For Retrospective Budgets Only)</b>				
1. Cash Aid		\$ _____	\$ _____	
2. Social Security, UIB, DIB, Pensions		_____	_____	
3. Child/Spousal Support		_____	_____	
4. Scholarships, Grants, Loans		_____	_____	
5. Other		_____	_____	
6. Total Gross Unearned Income (F1 + F2 + F3 + F4 + F5)		\$ _____	\$ _____	
7. Total Nonexempt Gross Income (E5 + F6)		\$ _____	\$ _____	
<b>G. STANDARD/DEPENDENT CARE DEDUCTION</b>				
1. Standard Deduction		\$ _____	\$ _____	
2. Dependent Care (Lesser of Actual or Maximum)		_____	_____	
3. Total Deductions (G1 + G2)		\$ _____	\$ _____	
4. Preliminary Adjusted Income (D2 - G3 or F7 - G3)		\$ _____	\$ _____	
<b>H. SHELTER DEDUCTION</b>				
1. Total Housing Costs		\$ _____	\$ _____	
2. Total Utility Costs (Actual or SUA)		_____	_____	
3. Total Shelter Costs		\$ _____	\$ _____	
4. Allowable Shelter Costs (50% of G4)		\$ _____	\$ _____	
5. Excess Shelter Costs (H3 - H4)		\$ _____	\$ _____	
6. Maximum Allowance for Shelter		\$ _____	\$ _____	
7. Allowable Shelter Deduction (Lesser of H5 or H6)		\$ _____	\$ _____	
<b>I. NET MONTHLY INCOME (G4 - H7)</b>		\$ _____	\$ _____	
<b>J. NET INCOME TEST</b>				
1. Household Size		_____	_____	
2. Maximum Net Income Allowed (from Table)		\$ _____	\$ _____	
3. Net Income Eligible? (Is I less than or equal to J2?)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PART 3 - BENEFITS</b>		ALLOTMENT	SUPPLEMENT	
E.W. Initials/Date				

**WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION**
**PART 4 — RESOURCES**

K. MOTOR VEHICLES		Vehicle (1)	Vehicle (2)	DOCUMENTATION		
1. Vehicle Owner				6. For licensed vehicles count the greater of the excess or equity value. For unlicensed vehicles count the equity value.		
Year/Class						
Make and Model						
Estimated Value						
Amount Owed						
Licensed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Value						
3. Excluded as home, income producing or transport handicapped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Values	(1)	(2)
4. Under \$4500 per table?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	FMV		
5. Exempt -				Minus \$4500		
For household use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excess Value		
For work, to seek work, school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	FMV		
				Minus Encumbrance		
				Equity Value		

If exempt and under \$4500 STOP here; do not go to 6.

**L. RESOURCE ELIGIBILITY (Nonexempt Resources Only)**

	Issuance Month	Issuance Month
1. Previous Month's Resources	\$ _____	\$ _____
2. Additional Resources (specify)		
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
3. Subtotal (L1 + L2a + L2b + L2c)	\$ _____	\$ _____
4. Resources Sold, Traded or Given Away (specify)		
a. _____	\$ _____	\$ _____
b. _____	_____	_____
c. _____	_____	_____
5. Subtotal (L4a + L4b + L4c)	\$ _____	\$ _____
6. Current Resources (L3 - L5)	\$ _____	\$ _____
7. Resource Eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART 5 — INCOME COMPUTATIONS**
**M. SELF-EMPLOYMENT**

	Issuance Month	Issuance Month
1. Gross income from Self-Employment	\$ _____	\$ _____
2. Expenses	_____	_____
3. Total Nonexempt Income from Self-Employment (M1 - M2)	\$ _____	\$ _____
If averaging self-employment income go to M7. If adjusting a previous average, continue to M4.		
4. Adjustment to Gross Income	\$ _____	\$ _____
5. Adjustment to Expenses	_____	_____
6. Adjusted Self-Employment Income (M3 ± M4 ± M5)	\$ _____	\$ _____
7. Monthly Self-Employment Income (M3 or M6 ÷ number of months income covers)	\$ _____	\$ _____

**N. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS**

	Issuance Month	Issuance Month
1. Income from Grants, Scholarships or Loans	\$ _____	\$ _____
2. Tuition and Mandatory Fees	_____	_____
3. Total Nonexempt Educational Income (N1 - N2)	\$ _____	\$ _____
4. Monthly Income from Grants, Scholarships or Loans (N3 ÷ number of months income covers)	\$ _____	\$ _____

**PART 6 — REPORTED CHANGES (Other than the CA 7 or DFA 377.5)**

Type of Change					
Date Change Occurred					
Date Change Reported					
EW Initials					

**Form Instructions**  
(For the Eligibility Worker)

**FOOD STAMP BUDGET WORKSHEET****Purpose:**

The DFA 285-B is used in conjunction with the application for food stamps (DFA 285-A2), or a monthly eligibility report (CA 7), or a household change report (DFA 377.5) to compute and document a household's eligibility and benefit level. The budget portion of the worksheet provides spaces for two separate budget computations. The change documentation portion of the worksheet is used for documenting resource changes, ongoing resource eligibility, and income computations resulting from information reported either at the time of application or during the certification period.

NOTE: The DFA 285-D, Food Stamp Budget Worksheet — Special Medical/Shelter Deductions, must be used for any household containing a member who is elderly or disabled.

**Preparation:**

Enter the following identifying information on the top of the front page of the worksheet:

- Case Name
- Case Number
- Companion Case Reference
- Household Classification

Enter the beginning and ending dates of the certification period; month and year. Enter the issuance month for the budget being computed, and complete the budget.

**Part 1 — Gross Income Eligibility**

Complete Sections A through C using prospective amounts to determine gross income eligibility.

See the attachment to these form instructions, the "DFA 285-B (4/86), Appendix — Offsetting A Farm Self-Employment Loss", for the steps necessary to perform the gross income eligibility test for households with a farm loss.

**C. Gross Income Test**

If the answer on Line C4 is "No", deny the application, or terminate or suspend eligibility, as appropriate. If the answer on Line C4 is "Yes" continue to Part 2.

**Part 2 — Net Income**

Check the appropriate box for a retrospective or prospective budget computation. When the net monthly income is used to determine net income eligibility, use prospective amounts. When the net monthly income is used to determine benefits, use either retrospective or prospective amounts, as appropriate.

\* These instructions contain information effective for the May 1, 1986 deduction and resource changes and the June 1, 1986 self-employment farmer regulations.



For a prospective budget, complete Section D and Sections G through I. For a retrospective budget, complete Sections E through I.

**I. Net Monthly Income**

After net monthly income has been determined, go to Section J when net income eligibility must also be determined.

When completing net income for benefits, skip Section J and go to Part 3.

**J. Net Income Test**

If the answer on Line J3 is "No", deny the application, or terminate or suspend eligibility, as appropriate. If the answer on Line J3 is "Yes", continue to Part 3.

**Part 3 — Benefits**

**Allotment**

Determine if benefits should be prorated and check the appropriate box (Yes or No) in the documentation section. Use the current Tables of Coupon Issuance, household size and net monthly income to find the allotment. If benefits should not be prorated, enter the amount from the table. If benefits should be prorated, compute the prorated amount using the date of application and the appropriate percentage for the month of application from the Reciprocal Table for Prorating First-Month Benefits. Enter the prorated amount.

**Supplement**

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter the amount of the supplement.

**Initials/Date**

Enter EW initials and date after any action in Parts 1, 2, or 3 of the budget worksheet.

**Subsequent Budgets**

If a subsequent budget is calculated, enter the issuance month, and complete as outlined above.

If a subsequent budget is not calculated but the first-month benefits were prorated, and the certification period is longer than one month, enter the amount of the household's full allotment for the second month.

\* These instructions contain information effective for the May 1, 1986 deduction and resource changes and the June 1, 1986 self-employment farmer regulations.

**Worksheet For Changes and Other Documentation****Part 4 — Resources**

Sections K and L need not be completed for a household in which all members are receiving Federal AFDC.

**K. Motor Vehicles**

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Complete the items for each vehicle using information provided by the household. A vehicle is licensed if the motor vehicle registration fees are paid for the current year. If not, skip 3 through 5 and go directly to 6.
2. Enter the value of the vehicle based on the blue book, CPI book, newspapers, etc., and document source used for valuation.
3. Evaluate vehicles for exclusion as a resource.
4. For licensed vehicles which are not excluded and which have a value greater than \$4,500, determine the fair market value.
5. Determine if any licensed vehicle is exempt from the equity valuation. Compute the equity value of all nonexempt vehicles.
6. Compute resource value of all nonexempt vehicles.

**L. Resource Eligibility**

Enter the issuance month for each resource eligibility test.

1. Enter the amount of resources used in the last resource eligibility test.
2. Specify any nonexcluded additions to the household's resources and enter the amount(s).
3. Add Lines L1, L2a, L2b, and L2c and enter the total.
4. Specify any nonexcluded subtractions from the household's resources and enter the amount(s).
5. Add Lines L4a, L4b and L4c and enter the total.
6. Subtract Line L5 from Line L3 and enter the remainder.

\* These instructions contain information effective for the May 1, 1986 deduction and resource changes and the June 1, 1986 self-employment farmer regulations.

7. If Line L6 is less than or equal to \$2,000, check "Yes". If Line L6 is greater than \$2,000, check "No". If the answer on Line L7 is "No", deny the application, or terminate or suspend eligibility, as appropriate.

#### **Part 5 — Income Computations**

##### **M. Self-Employment**

Enter the issuance month for each self-employment income calculation and complete Lines M1 through M3. If M2 is greater than M1 because of a farm self-employment loss, refer to the "DFA 285-B (4/86) Appendix — Offsetting A Farm Self-Employment Loss" for the steps necessary to determine self-employment income.

If self-employment income is to be averaged, go to Line M7. If previously averaged self-employment income is to be adjusted, complete Lines M4 through M7.

Enter the amount from either Line M3 or Line M7 in the appropriate budget.

##### **N. Educational Grants, Scholarships and Loans**

Complete this section if the household has income from educational grants, scholarships, or loans.

Enter the issuance month for each calculation and complete Lines N1 through N4. Enter the amount on Line N4 in the appropriate budget.

#### **Part 6 — Reported Changes**

For changes reported outside of the monthly report (CA, 7) or the household change report (DFA 377.5), enter the type of change, date the change occurred, date the change was reported, and the EW initials.

\* These instructions contain information effective for the May 1, 1986 deduction and resource changes and the June 1, 1986 self-employment farmer regulations.

## DFA 285-B (4/86) — APPENDIX — OFFSETTING FARM SELF-EMPLOYMENT LOSSES

Effective June 1, 1986 for applications and effective for the July allotment for continuing cases, a household containing a self-employed farmer (MPP63-102s) may offset its losses from a farming enterprise by subtracting the loss from other countable income in the following order:

- Subtract the farm self-employment loss from other monthly self-employment income in the household.
- Subtract the remaining loss from other unearned income in the household.
- Subtract any remaining loss from earned income in the household.

If the household's other countable income is either zero or is not sufficient to completely offset the loss, the household's total nonexempt income becomes zero.

The chart below outlines the steps for computing the farm self-employment loss, performing the gross and net income eligibility tests and benefit computation for the three types of households involving farm losses.

- Column 1 is for households with a farm self-employment loss and no other self-employment income.
- Column 2 is for households with a farm self-employment loss and other self-employment income that cannot completely offset the farm loss as the other self-employment income is less than the farm loss.
- Column 3 is for households with a farm self-employment loss and other self-employment income that can completely offset the farm loss as the other self-employment income is less than the farm loss.

**NOTE:** When offsetting is complete, you will be instructed to return to a specified step on the DFA 285-B (4/86) worksheet. Example: "Return to DFA 285-B (4/86), Part 1, C1."

SELF-EMPLOYMENT INCOME COMPUTATION

(1)	(2)	(3)
FARM SELF-EMPLOYMENT LOSS/ NO OTHER SELF-EMPLOYMENT INCOME	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (LESS THAN FARM SELF-EMPLOYMENT LOSS)	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (GREATER THAN FARM SELF-EMPLOYMENT LOSS)

Enter the issuance month for each self-employment income calculation and complete Lines M1 through M3. Subtract M2 from M1 and enter the total loss in M3 when M2 is greater than M1.

N A

Prepare two computations: one for the farm self-employment income and one for the other self-employment income. Note which computation is for the farm self-employment.

If the farm self-employment loss is to be averaged, go to Line M7. If the previously averaged self-employment loss is to be adjusted, complete Lines M4 through M7.

N A

Subtract the farm self-employment loss from the gains from other (non-farm) self-employment income.

N A

**NOTE:** A farm self-employment loss cannot be added to any other self-employment loss.

When farm self-employment losses are greater than farm self-employment income, offsetting is required against other unearned income, and, if necessary other earned income. Go to Gross Income Eligibility below.

When the other self-employment income is less than the farm self-employment loss, offsetting is required against other unearned income, and, if necessary, other earned income. Go to Gross Income Eligibility below.

When the other self-employment income is greater than the farm self-employment loss, enter the difference between the other self-employment gain and the farm self-employment loss in Part 1, A2. Offsetting is complete. Return to DFA 285-B (4/86), Worksheet, Part 1, Step A.

GROSS INCOME ELIGIBILITY

(1)	(2)	(3)
FARM SELF-EMPLOYMENT LOSS/ NO OTHER SELF-EMPLOYMENT INCOME	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (LESS THAN FARM SELF-EMPLOYMENT LOSS)	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (GREATER THAN FARM SELF-EMPLOYMENT LOSS)

GROSS INCOME ELIGIBILITY

Complete Sections A through C using prospective amounts to determine gross income eligibility.

Enter zero in A2 when a net loss is determined in Section M.

In B5, enter the monthly farm self-employment loss calculated in Section M. Subtract the farm loss in B-5 from any other nonexempt gross unearned income in B5.

If no farm loss remains, offsetting is complete. Return to DFA 285-B (4/86), Worksheet, Part 1, B6.

Subtract any remaining farm loss in B5 from the total of all other unearned income (B1 + B2 + B3 + B4).

If the farm loss in B5 is less than the total gross unearned income, offsetting is complete. Enter the difference in B6. Return to DFA 285-B (4/86), Worksheet, Part 1, C1.

If the farm loss in B5 is greater than the total gross unearned income, enter the remaining loss in B6. Subtract the loss from the gross earned income (A4-B6).

If the gross earned income in A4 is greater than the farm loss in B6, offsetting is complete. Enter the difference in C3. Return to DFA 285-B (4/86), Worksheet, Part 1, C1.

If the farm loss in B6 exceeds the gross earned income in A4, enter zero in C3, as the remaining farm loss cannot be offset. In C4, check yes. Goto Net Monthly Income below.

NET MONTHLY INCOME

(1)	(2)	(3)
FARM SELF-EMPLOYMENT LOSS/ NO OTHER SELF-EMPLOYMENT INCOME	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (LESS THAN FARM SELF-EMPLOYMENT LOSS)	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (GREATER THAN FARM SELF-EMPLOYMENT LOSS)

NET MONTHLY INCOME

Check the appropriate box for a retrospective or prospective budget computation. When the net monthly income is used to determine net income eligibility, use prospective amounts. When the net monthly income is used to determine benefits, use retrospective amounts, as appropriate.

PROSPECTIVE BUDGET

When C3 is zero because farm self-employment losses are greater than gross earned income as determined in Part 1, any remaining loss cannot be offset. Enter zero in D2. Offsetting is complete. Return to DFA 285-B(4-86), Worksheet, Part J.

RETROSPECTIVE BUDGET

Follow the procedures outlined above in **Gross Income Eligibility** when completing net income (Sections E and F) retrospectively for a household with a farm self-employment loss.

Form-Related Information

Revision of Form and Eligibility Worker Instructions

This will provide you with advance notice that this form and the form instructions for the eligibility worker will be revised in the next few months primarily to include the following federal changes into State regulations:

- o a requirement that all Food Stamp applications be signed by one adult household member.
- o inclusion of a penalty of perjury statement on all applications for food stamps.
- o revision of the definition of disabled to include new groups of individuals

Other proposed changes to this form are the inclusion of the specific Intentional Program Violation penalties and minor modifications to the text.

An implementation date of December 1, 1986 has been targeted for the adult household signature requirement. Implementation dates for the other new federal changes have not as yet been proposed.

Please monitor your stock levels of the current version of the DFA 285-C(12/83) as the pending revision will obsolete the (12/83) version.



## Form-Related Information

### Revision of Form

Attachment D-1 provides an advance copy of the revised DFA 285-D(6/86). The only change to the form was to revise Part 1, Step A.5 to read "Adjusted Gross Earned Income (80% of A4)". CWDs that locally reproduce stock may use the attached copy as a master to replace the first page of the prior version (the DFA 285-D(12/83)).

### Form Instructions for the Eligibility Worker

Attachment D-2 provides revised Eligibility Worker form instructions for the DFA 285-D(6/86). The instructions contain information relating to the May 1, 1986 resource and deduction changes and the June 1, 1986 farm self-employment offset regulations previously addressed in ACL 86-22 and ACL 86-41 respectively. An Attachment to these instructions, the DFA 285-D(6/86) Appendix - "Offsetting a Farm Self-Employment Loss" provides the steps for computing the self-employment loss, and for performing the net income eligibility test and benefit computation for those households containing a self-employed farmer.

### Implementation

The DFA 285-D(6/86) does not obsolete the prior version, the DFA 285-D(12/83). County Welfare Departments (CWDs) may continue to use (12/83) stock until it is depleted. CWDs are reminded, however, that the Part 1, Step A-5 calculation on the DFA 285-D(12/83) reflects the pre May 1, 1986 income deduction of 82 percent. Instructions for manual correction of prior stock were outlined in ACL 86-22 and ACL 86-42.

### Ordering of Stock

Orders for the DFA 285-D(6/86) should be submitted on the GEN 727B, County Forms Order, according to normal procedures. CWDs are not authorized to return stock of the DFA 285-D(12/83) for credit.

# FOOD STAMP BUDGET WORKSHEET - Special Medical/Shelter Deductions

CASE NAME	CASE NUMBER	COMPANION CASE REFERENCE	CLASSIFICATION <input type="checkbox"/> NA <input type="checkbox"/> PA <input type="checkbox"/> MIXED
CERTIFICATION PERIOD FROM _____ THROUGH _____	<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective	<input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective	<b>DOCUMENTATION</b>
<b>PART 1 — NET MONTHLY INCOME</b>	Issuance Month _____	Issuance Month _____	
<b>A. NONEXEMPT GROSS EARNED INCOME</b>			
1. Gross Salary, Wages	\$ _____	\$ _____	
2. Self-Employment	_____	_____	
3. Training Allowance	_____	_____	
4. Total Gross Earned Income (A1 + A2 + A3)	\$ _____	\$ _____	
5. Adjusted Gross Earned Income (80% of A4)	\$ _____	\$ _____	
<b>B. NONEXEMPT GROSS UNEARNED INCOME</b>			
1. Cash Aid	\$ _____	\$ _____	
2. Social Security, UIB, DIB, Pensions	_____	_____	
3. Child/Spousal Support	_____	_____	
4. Scholarships, Grants, Loans	_____	_____	
5. Other	_____	_____	
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)	\$ _____	\$ _____	
<b>C. TOTAL NONEXEMPT GROSS INCOME (A5 + B6)</b>	\$ _____	\$ _____	
<b>D. EXCESS MEDICAL EXPENSES</b>			
1. Recurring Expenses	\$ _____	\$ _____	
2. One-Month-Only Expenses	_____	_____	
3. Averaged Expenses	_____	_____	
4. Total Allowable Expenses (D1 + D2 + D3)	\$ _____	\$ _____	
5. Medical Expense Allowance (\$35)	\$ _____	\$ _____	
6. Excess Medical Expenses (D4 - D5)	\$ _____	\$ _____	
<b>E. STANDARD/DEPENDENT CARE/MEDICAL DEDUCTIONS</b>			
1. Standard Deduction	\$ _____	\$ _____	
2. Dependent Care (Lesser of Actual or Maximum)	_____	_____	
3. Excess Medical Expenses (From D6)	_____	_____	
4. Total Deductions (E1 + E2 + E3)	\$ _____	\$ _____	
5. Total Adjusted Income (C - E4)	\$ _____	\$ _____	
<b>F. SHELTER DEDUCTION</b>			
1. Total Housing Costs	\$ _____	\$ _____	
2. Total Utility Costs (Actual or SUA)	_____	_____	
3. Total Shelter Costs	\$ _____	\$ _____	
4. Allowable Shelter Costs (50% of E5)	\$ _____	\$ _____	
5. Excess Shelter Costs (F3 - F4)	\$ _____	\$ _____	
<b>G. NET MONTHLY INCOME (E5 - F5)</b>	\$ <span style="border: 1px solid black; padding: 2px 20px;"> </span>	\$ <span style="border: 1px solid black; padding: 2px 20px;"> </span>	
<b>PART 2 — NET INCOME ELIGIBILITY</b>			
<b>H. NET INCOME TEST</b>			
1. Household Size	_____	_____	
2. Maximum Net Income Allowed (From Table)	\$ _____	\$ _____	
3. Net Income Eligible? (Is G less than or equal to H2?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PART 3 — BENEFITS</b>	ALLOTMENT	SUPPLEMENT	
E.W. Initials/Date			First-Month Benefits Prorated? <input type="checkbox"/> Yes <input type="checkbox"/> No

**WORKSHEET FOR CHANGES AND OTHER DOCUMENTATION**
**PART 4 — RESOURCES**
**DOCUMENTATION**

I. MOTOR VEHICLES		Vehicle (1)	Vehicle (2)	
1. Vehicle Owner				
Year/Class				
Make and Model				
Estimated Value				
Amount Owed				
Licensed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Value				
3. Excluded as home, income producing or transport handicapped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Under \$4500 per table?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Exempt -				
For household use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
For work, to seek work, school or training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				6. For licensed vehicles count the greater of the excess or equity value. For unlicensed vehicles count the equity value.
				Values (1) (2)
				FMV
				Minus \$4500
				Excess Value
				FMV
				Minus Encumbrance
				Equity Value

If exempt and under \$4500 STOP here; do not go to 6.

**J. RESOURCE ELIGIBILITY (Nonexempt Resources Only)**

	Issuance Month	Issuance Month
1. Previous Month's Resources	\$ _____	\$ _____
2. Additional Resources (specify)		
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
3. Subtotal (J1 + J2a + J2b + J2c)	\$ _____	\$ _____
4. Resources Sold, Traded or Given Away (specify)		
a. _____	\$ _____	\$ _____
b. _____	_____	_____
c. _____	_____	_____
5. Subtotal (J4a + J4b + J4c)	\$ _____	\$ _____
6. Current Resources (J3 - J5)	\$ _____	\$ _____
7. Resource Eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART 5 — INCOME COMPUTATIONS**
**K. SELF-EMPLOYMENT**

	Issuance Month	Issuance Month
1. Gross Income from Self-Employment	\$ _____	\$ _____
2. Expenses	_____	_____
3. Total Nonexempt Income from Self-Employment (K1 - K2)	\$ _____	\$ _____
If averaging self-employment income go to K7. If adjusting a previous average, continue to K4.		
4. Adjustment to Gross Income	\$ _____	\$ _____
5. Adjustment to Expenses	_____	_____
6. Adjusted Self-Employment Income (K3 ± K4 ± K5)	\$ _____	\$ _____
7. Monthly Self-Employment Income (K3 or K6 ÷ number of months income covers)	\$ _____	\$ _____

**L. EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS**

	Issuance Month	Issuance Month
1. Income from Grants, Scholarships or Loans	\$ _____	\$ _____
2. Tuition and Mandatory Fees	_____	_____
3. Total Nonexempt Educational Income (L1 - L2)	\$ _____	\$ _____
4. Monthly Income from Grants, Scholarships or Loans (L3 ÷ number of months income covers)	\$ _____	\$ _____

**PART 6 — REPORTED CHANGES (Other than the CA 7 or DFA 377.5)**

Type of Change				
Date Change Occurred				
Date Change Reported				
EW Initials				

**Form Instructions**  
(For the Eligibility Worker)

**FOOD STAMP BUDGET WORKSHEET — SPECIAL MEDICAL/SHELTER DEDUCTIONS**

**Purpose:**

The DFA 285-D is used in conjunction with the application for food stamps (DFA 285-A2) and the food stamp application for special medical deductions (DFA 285-C), or a monthly eligibility report (CA 7), or a household change report (DFA 377.5) to compute and document the eligibility and benefit level for a household which has a member who is elderly or disabled. The budget portion of the worksheet provides spaces for two separate budget computations. The change documentation portion of the worksheet is used for documenting resource changes, ongoing resource eligibility, and income computations resulting from information reported either at the time of application or during the certification period.

**Preparation:**

Enter the following identifying information on the top of the front page of the worksheet:

- Case name
- Case number
- Companion Case Reference
- Household Classification

Enter the beginning and ending dates of the certification period; month and year. Enter the issuance month for the budget being computed, check the appropriate box for a retrospective or prospective budget and complete the budget.

**Part 1 — Net Monthly Income**

Complete Sections A through G to determine the household's net monthly income. When the net monthly income is used to determine net income eligibility, use prospective amounts. When the net monthly income is used to determine benefits, use either prospective or retrospective amounts, as appropriate.

See the attachment to these form instructions, the "DFA 285-D (6/86), Appendix — Offsetting A Farm Self-Employment Loss" for the steps necessary to determine net monthly income for households with a farm self-employment loss.

After net monthly income has been determined, go to Part 2 when net income eligibility must be determined.

If the household's net income eligibility has already been determined, skip Part 2 and go to Part 3.

**Part 2 — Net Income**

**H. Net Income Test**

If the answer on Line H3 is "No", deny the application, or terminate or suspend the household, as appropriate. If the answer on Line H3 is "Yes", go to Part 3.

**Part 3 — Benefits****Allotment**

Determine if benefits should be prorated and check the appropriate box (Yes or No) in the documentation section. Use the current Tables of Coupon Issuance, household size and net monthly income to find the allotment. If benefits should not be prorated, enter the amount from the table. If benefits should be prorated, compute the prorated amount using the date of application and the appropriate percentage for the month of application from the Reciprocal Table for Prorating First-Month Benefits. Enter the prorated amount.

**Supplement**

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter the amount of the supplement.

**Initials/Date**

Enter EW initials and date after any action in Parts 1, 2 or 3 of the budget worksheet.

**Subsequent Budgets**

If a subsequent budget is calculated, enter the issuance month, check if the budget calculation is retrospective or prospective and complete as outlined above.

If a subsequent budget is not calculated but the first-month benefits were prorated, and the certification period is longer than one month, enter the household's full allotment for the second month.

**Worksheet for Changes and Other Documentation****Part 4 — Resources**

Sections I and J need not be completed for a household in which all members are receiving Federal AFDC.

**I. Motor Vehicles**

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Complete the items for each vehicle using information provided by the household. A vehicle is licensed if the motor vehicle registration fees are paid for the current year. If not licensed, skip 3 through 5 and go directly to 6.

2. Enter the value of the vehicle based on the blue book, CPI book, newspapers, etc., and document source used for valuation.
3. Evaluate vehicles for exclusion as a resource.
4. For licensed vehicles which are not excluded and which have a value greater than \$4,500, determine the fair market value.
5. Determine if any licensed vehicle is exempt from the equity valuation. Compute the equity value of all nonexempt vehicles.
6. Compute resource value of all nonexempt vehicles.

#### J. Resource Eligibility

Enter the issuance month for each resource eligibility test.

1. Enter the amount of resources used in the last resource eligibility test.
2. Specify any nonexcluded additions to the household's resources and enter the amount(s).
3. Add Lines J1, J2a, J2b, and J2c and enter the total.
4. Specify any nonexcluded subtractions from the household's resources and enter the amount(s).
5. Add Lines J4a, J4b and J4c and enter the total.
6. Subtract Line J5 from Line J3 and enter the remainder.
7. If Line J6 is less than or equal to \$2,000, (or \$3,000 for households with an elderly member) check "Yes"; if Line J6 is greater than \$2,000 (or \$3,000 for households with an elderly member), check "No". If the answer on Line J7 is "No", deny the application, or terminate or suspend eligibility as appropriate.

### Part 5 — Income Computations

#### K. Self-Employment

Enter the issuance month for each self-employment income calculation and complete Lines K1 through K3. If K2 is greater than K1, because of a farm self-employment loss, refer to the "DFA 285-D (6/86), Appendix— Offsetting A Farm Self-Employment Loss" for the steps to determine self-employment income.

If self-employment income is to be averaged, go to Line K7. If previously averaged self-employment income is to be adjusted, complete Lines K4 through K7.

#### L. Educational Grants, Scholarships and Loans

Complete this section if the household has income from educational grants, scholarships, or loans.

Enter the issuance month for each calculation and complete Lines L1 through L4. Enter the amount on Line L4 on Line B4 of the appropriate budget.

**Part 6 — Reported Changes**

For changes reported outside of the monthly report (CA 7) or the household change report (DFA 377.5), enter the type of change, date the change occurred, date the change was reported, and the EW initials.

**DFA 285-D (6/86) — APPENDIX — OFFSETTING FARM SELF-EMPLOYMENT LOSSES**  
(Special Medical/Shelter Deductions)

Effective June 1, 1986 for applications and effective for the July allotment for continuing cases, a household with a self-employed farmer (MPP63-102s) may offset its losses from a farming enterprise by subtracting the loss from other countable income in the following order:

- Subtract the farm self-employment loss from other monthly self-employment income in the household.
- Subtract the remaining loss from other unearned income in the household.
- Subtract any remaining loss from earned income in the household.

If the household's other countable income is either zero or is not sufficient to completely offset the loss, the household's total nonexempt income becomes zero.

The chart below outlines the steps for computing the farm self-employment loss, for the three types of households involving a farm loss.

- Column 1 is for households with a farm self-employment loss and no other self-employment income.
- Column 2 is for households with a farm self-employment loss and other self-employment income that cannot completely offset the farm loss as the other self-employed income is less than the farm loss.
- Column 3 is for households with a farm self-employment loss and other self-employment income that can completely offset the farm loss as the other self-employment income is greater than the farm loss.

**NOTE:** When offsetting is complete, you will be instructed to return to a specified step on the DFA 285-D (6/86) worksheet.  
Example: "Return to DFA 285-D (6/86), Part 1, C1".



# SELF-EMPLOYMENT INCOME COMPUTATION

(1)	(2)	(3)
FARM SELF-EMPLOYMENT LOSS/ NO OTHER SELF-EMPLOYMENT INCOME	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (LESS THAN THE FARM SELF-EMPLOYMENT LOSS)	FARM SELF-EMPLOYMENT LOSS/ OTHER SELF-EMPLOYMENT INCOME (GREATER THAN THE FARM SELF-EMPLOYMENT LOSS)

Enter the issuance month for each self-employment income calculation and complete Lines K1 through K3. Subtract K2 from K1 and enter the total loss in K3 when K2 is greater than K1.

N/A

Prepare two computations: one for the farm self-employment income and one for the other self-employment income. Note which computation is for the farm self-employment.

If the farm self-employment loss is to be averaged, go to Line K7. If the previously averaged self-employment loss is to be adjusted, complete Lines K4 through K7.

N/A

Subtract the farm self-employment loss from the gains from other (non-farm) self-employment income. Enter the difference at K3.

**NOTE:** A farm self-employment loss cannot be added to other self-employment losses.

When a farm self-employment loss is greater than self-employment farm income, offsetting is required against unearned income and, if necessary, earned income. Go to Net Monthly Income below.

When the other self-employment income is less than the farm self-employment loss, offsetting is required against unearned income and, if necessary, earned income. Go to Net Monthly Income below.

When the other self-employment income is greater than the farm self-employment loss, enter the difference between the other self-employment gain and the farm self-employment loss in Part 1A2. Offsetting is complete. Return to DFA 285-D (6/86), Worksheet, Part 1 A.

# NET MONTHLY INCOME

(1)	(2)	(3)
FARM SELF-EMPLOYMENT LOSS NO OTHER SELF-EMPLOYMENT INCOME	FARM SELF-EMPLOYMENT LOSS OTHER SELF-EMPLOYMENT INCOME (LESS THAN FARM SELF-EMPLOYMENT LOSS)	FARM SELF-EMPLOYMENT LOSS OTHER SELF-EMPLOYMENT INCOME (GREATER THAN FARM SELF-EMPLOYMENT LOSS)

## NET INCOME ELIGIBILITY

Complete Sections A through G to determine the household's net monthly income. When the net monthly income is used to determine net income eligibility, use prospective amounts; when the net monthly income is used to determine benefits, use either prospective or retrospective amounts as appropriate.

Enter zero in A2 when a net loss is determined in Section K.

In B5, enter the monthly farm self-employment loss calculated in Section K. Subtract the farm loss in B-5 from any other nonexempt gross unearned income in B5.

If no farm loss remains, offsetting is complete. Return to DFA 285-D (6/86), Worksheet, Part 1, B6.

Subtract the remaining farm loss in B5 from the total of all other unearned income (B1 + B2 + B3 + B4).

If the farm loss in B5 is less than the total gross unearned income, offsetting is complete. Enter the difference in B6. Return to DFA 285-D (6/86), Worksheet, Part 1, C.

If the farm loss in B5 is greater than the total gross unearned income, enter the remaining loss in B6. Subtract the loss from the adjusted gross earned income in A5 (A5-B6).

If the adjusted gross earned income in A5 is greater than the farm loss in B6, offsetting is complete. Enter the difference in C. Return to DFA 285-D (6/86), Worksheet, Part 1, D1.

If the farm loss in B6 exceeds the total in A4, enter zero in C and G, as the remaining farm loss cannot be offset. Offsetting is complete. Go to DFA 285-D, Worksheet Part 2, H1.

### Form-Related Information

#### Revision of Form

Attachments E-1 and E-2 provide advance copies of the revised English and Spanish language versions of the DFA 377.5(6/86). Those counties requiring translations in languages other than Spanish should contact Jeanne Rodriguez, Manager, Language Services Unit at 916-323-9562.

#### Outline of Major Changes to Form

Major changes from the prior (12/83) version of the DFA 377.5 are:

- Question 3B was revised to read "...reach or exceed \$2,000".
- The Social Security Number footnote on page 1 was revised to match the narrative on the DFA 285-A2(12/85).
- The Certification Section was revised to include the specific disqualification penalties for Intentional Program Violations.

#### Form Instructions for the Eligibility Worker

Attachment E-3 provides revised form instructions for the eligibility worker for the DFA 377.5(6/86). Changes include updates and/or revisions to the text and cited manual section numbers.

#### Implementation of the Revised Form

The DFA 377.5(6/86) does not obsolete the DFA 377.5(12/83) stock, except as noted above in the "Forms Implementation Policy" section of this letter.

#### Ordering

Orders for the DFA 377.5(6/86) should be submitted on the GEN 727B, County Forms Order, according to normal procedures. CWDs are not authorized to return stock of the DFA 377.5(12/83) for credit.

# FOOD STAMP HOUSEHOLD CHANGE REPORT

Attachment E-1

## INSTRUCTIONS:

You must report changes in your household circumstances within 10 days of the time you learn of any change.  
You may use this form to report changes or you may report changes in person or by calling the number below.  
If you use these forms, you only have to complete the sections that apply to the changes you are reporting.  
If you have any questions about your reporting responsibilities or any doubt about needing to report a change, please contact your worker.



Worker:

Phone:

### ① INCOME CHANGES

- A. Did the total amount of income received by your household increase or decrease by more than \$25? If YES, complete 1C below. ☐ YES
- B. Did the source of income received by any household member change or did anyone begin receiving income from a new source? If YES, complete 1C below. ☐ YES
- C. If YES to ①A or ①B above, enter all income received by your household. Attach paystubs or other proof of earnings. For all other income attach proof when a change is reported. If anyone is self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

Name	Source (If Earnings, List Name of Employer)	Amount (Before Deductions)	How Often Received?	Date of Change
1.		\$		
2.		\$		
3.		\$		

### ② HOUSEHOLD COMPOSITION CHANGES

Change	YES	Date of Change	If YES, give name of person and explain change.
A. Did anyone move into your home, including a newborn?			
B. Did anyone move out of your home or die?			
C. Did anyone get married?			
D. Did anyone become disabled or recover from a disability?			
E. Did anyone turn age 60?			
F. Did anyone get a new Social Security Number * If YES, attach proof.			

### ③ RESOURCE CHANGES

- A. Did anyone buy or get a licensed vehicle? If YES, complete section below: ☐ YES

Vehicle Owner	Year and Class	Make and Model	Estimated Value	Amount Owed
			\$	\$

- B. Did the total of your household's cash on hand, money in a checking and/or savings account, stocks, bonds, etc. reach or exceed \$2,000? ☐ YES

If YES, complete section below:

List Each Item	Amount	Date of Change
1.	\$	
2.	\$	
3.	\$	

### ④ MEDICAL EXPENSE CHANGES

- Did the total amount of medical expenses for a household member who is disabled or age 60 or older increase or decrease by more than \$25? If YES, attach receipts and complete section below: ☐ YES

Who Had the Expense?	Type of Expense	Amount	Who Had the Expense?	Type of Expense	Amount
1.		\$	3.		\$
2.		\$	4.		\$

\*Any person that does not provide a social security number will be disqualified from receiving food stamps. Disclosure of a Social Security Number (SSN) is required by the Food Stamp Act of 1977, as amended by Public Law 97-98, for each food stamp household member. These SSNs will be used to check identity, prevent duplicate participation and to make changes. The SSNs and any other information provided, will also be used in computer matching and program reviews or audits to ensure issuance of benefits to eligible individuals participating in the Food Stamp Program or other federal assistance programs, such as: school lunch, Cash Aid or Medi-Cal. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims.

**⑤ ADDRESS AND SHELTER COST CH. ES**☐ YES  
☐ YESA. Do you have a new mailing address or phone number or do you plan to move? If **YES**, complete ⑤ C.B. Did you move? If **YES**, complete ⑤ C and ⑤ D.

C. Enter your new address and/or phone number below and enter the date of the change here:

Home Address (Number, Street Name, Ave., Blvd., Etc.) Apt. No. City State Zip Code

Mailing Address (If different than home address) Phone No. City State Zip Code

D. Did your housing or utility costs change when you moved? If **YES**, complete 1, 2 and 3 below: ☐ YES

1. Enter the amount of each housing cost you have and attach bills for each cost.

Rent or Mortgage: \$		Property Taxes or Insurance: \$ (If not in mortgage)	
Utility	Amount	Utility	Amount
Gas or Fuel	\$	Garbage or Trash	\$
Electricity	\$	Water	\$
Telephone	\$	Sewage	\$
Utility Installation	\$	Other (specify)	\$

2. If you claim actual utility costs, enter the amount of each utility cost you have and attach bills for each cost.

If you claim the standard utility allowance, attach bills for gas, electricity or other heating fuel.

3. Did anyone not part of your food stamp household help you pay any of your housing or utility costs? If **YES**, complete 3a, b and c below. ☐ YES

a. Enter the total housing costs paid by the food stamp household: \$

c. Give the name of each person who paid any of the costs, and if they paid housing and/or utility costs.

b. Enter the total utility costs paid by the food stamp household: \$

**⑥ DEPENDENT CARE EXPENSE CHANGES**

Did you begin paying or has there been a change in the amount paid for the care of a child or disabled adult so that someone in the home could go to work, training or look for a job?

If **YES**, complete section below and attach a receipt. ☐ YES

Who Received Care?	Cost of Care	Who Received Care?	Cost of Care	Who Received Care?	Cost of Care	Who Received Care?	Cost of Care
1.		2.		3.		4.	

**⑦ DISQUALIFIED INDIVIDUALS/INELIGIBLE ALIENS**

Did any person living in your home who is an ineligible alien or who has been disqualified from the Food Stamp Program have any of the changes in questions ① through ⑥?

If **YES**, give the name of the person and the date of the change, and explain the change below: ☐ YES**⑧ OTHER CHANGES**Do you have any other changes to report? If **YES**, explain below. ☐ YES**⑨ TEMPORARY CHANGES**Do you expect any of the changes reported on this form to be temporary? If **YES**, explain below. ☐ YES**CERTIFICATION**

- I understand that failing to report information or intentional misrepresentation of facts can result in legal prosecution with penalties of a fine, imprisonment or both. The penalties can result in disqualification from the Program, fines up to \$10,000 and imprisonment up to 5 years. The disqualification penalties are 6 months for the first violation, 12 months for the second violation, and permanent disqualification for the third violation.
- I understand that I have only 10 days to notify my worker of changes in my household circumstances.
- I understand that the information I have provided will be verified by local, state and federal personnel.
- I understand that if I fail to report a change and because of this I receive food stamps I am not entitled to, I will have to repay these benefits.
- I understand that I have the right to request a state hearing on any action by the County Welfare Department.
- I declare that the information contained in this report is true and correct.

Signature (Household Member or Authorized Representative)

Date

Signature (Witness, if You Signed with an X)

Date

COUNTY USE SECTION

E.W. Initials

Date

# REPORTE DE CAMBIO EN EL HOGAR DE ESTAMPILLAS PARA COMIDA

## INSTRUCCIONES:

Tiene que reportar los cambios en las circunstancias de su hogar dentro de 10 días de la fecha en que usted se entere de ellos. Puede usar esta forma para reportar cambios o los puede reportar en persona o llamando al número de teléfono indicado abajo. Si usa estas formas, sólo tiene que completar las secciones que apliquen a los cambios que esté reportando. Si tiene cualesquier preguntas respecto a su responsabilidad de reportar o cualquier duda sobre si necesita reportar un cambio, por favor comuníquese con su trabajador(a).

Trabajador(a):

Teléfono:

### 1 CAMBIO DE INGRESOS

- A. ¿Ha aumentado o disminuido la cantidad total de ingresos recibidos por su hogar más de \$25 dls.? SI ES ASÍ, complete la 1C abajo. ☐ sí
- B. ¿Ha cambiado la fuente de ingresos recibida por cualquier miembro del hogar o alguien ha comenzado a recibir ingresos provenientes de una nueva fuente? SI ES ASÍ, complete la 1C abajo. ☐ sí
- C. Si contestó que SÍ a la 1A o 1B anterior, anote todos los ingresos recibidos por su hogar. Adjunte talones de pago u otra prueba de sus ganancias. Adjunte comprobantes para todos los otros ingresos cuando se reporte un cambio. Si alguien trabaja por cuenta propia, anote los gastos del negocio en una hoja aparte y adjunte prueba de sus ingresos y gastos.

Nombre	Fuente (Si es sueldo, escriba el nombre del patrón)	Cantidad (Antes de las deducciones)	Recibida cada	Fecha del cambio
1.		\$		
2.		\$		
3.		\$		

### 2 CAMBIOS EN LA COMPOSICIÓN DEL HOGAR

Cambio	sí	Fecha del cambio	SI ES ASÍ, dé el nombre de la persona y explique el cambio
A. ¿Se ha mudado alguien a su hogar, incluso un recién nacido?			
B. ¿Se ha mudado alguien de su hogar, o ha fallecido alguien?			
C. ¿Se ha casado alguien?			
D. ¿Se ha incapacitado o recuperado de una incapacidad alguien?			
E. ¿Ha cumplido alguien los 60 años de edad?			
F. ¿Ha obtenido alguien un nuevo número de seguro social?*			
SI ES ASÍ, adjunte comprobante.			

### 3 CAMBIOS DE RECURSOS

- A. ¿Ha comprado u obtenido alguien un vehículo registrado? SI ES ASÍ, complete la siguiente sección: ☐ sí

Propietario del vehículo	Año y Clase	Marca y Modelo	Valor estimado	Cantidad que se debe
			\$	\$

- B. ¿Sumó o excedió el total de su dinero en efectivo, en una cuenta de cheques y/o ahorros, acciones, bonos, etc. la cantidad de \$2,000 dls.? ☐ sí

SI ES ASÍ, complete la siguiente sección:

Anote cada recurso	Cantidad	Fecha del cambio
1.	\$	
2.	\$	
3.	\$	

### 4 CAMBIOS EN GASTOS MÉDICOS

- ¿Ha aumentado o disminuido la cantidad total de gastos médicos para un miembro del hogar que esté incapacitado o tenga 60 años o más de edad por más de \$25 dls.? SI ES ASÍ, adjunte los recibos y complete la siguiente sección: ☐ sí

¿Quién hizo el gasto?	Tipo de gasto	Cantidad	¿Quién hizo el gasto?	Tipo de gasto	Cantidad
1.		\$	3.		\$
2.		\$	4.		\$

Las personas que no proporcionen un número de seguro social serán descalificadas para recibir estampillas para comida. El Acta de Estampillas para Comida de 1977, según enmienda de la Ley Pública 97-98, requiere que se revele el Número de Seguro Social (SSN) para cada miembro del hogar para fines de estampillas para comida. Estos SSN van a ser usados para corroborar la identidad, evitar duplicidad de participación y para hacer corroboraciones por medio de computadoras y para revisiones o auditorías del programa con el fin de asegurar que se otorguen beneficios a individuos que califiquen y que participen en el Programa de Estampillas para Comida u otros programas de asistencia federal, por ejemplo: almuerzos escolares, asistencia monetaria o Medi-Cal. La participación fraudulenta en el Programa de Estampillas para Comida puede resultar en acciones de carácter criminal o civil o en reclamaciones administrativas.

**5 CAMBIO DE DOMICILIO Y COSTO DE RENTA**

A. ¿Tiene una nueva dirección de correo o no. de teléfono o planea mudarse? SI ES ASÍ, complete ⑤ C.

B. ¿Se mudó? SI ES ASÍ, complete ⑤ C y ⑤ D.

C. Escriba su nueva dirección y/o no. de teléfono abajo y escriba la fecha del cambio aquí:

Domicilio del Hogar (Número, Nombre de la Calle, Avenida, Bulevar, etc.) No. de Apto. Ciudad Estado Zona Postal

Dirección de Correo (si es diferente que el domicilio del hogar) No. de Teléfono Ciudad Estado Zona Postal

D. ¿Cambiaron sus costos de vivienda o de servicios públicos y municipales cuando se mudó? SI ES ASÍ, complete las secciones

☐ SÍ

1, 2 y 3 a continuación:

1. Escriba la cantidad de cada costo de vivienda que tenga y adjunte los cobros por cada costo.

Renta o Hipoteca: \$ Impuestos sobre propiedad o Seguro: \$  
(Si no están incluidos en la hipoteca)

2. Si reclama el costo real de los servicios públicos y municipales, escriba el costo de cada servicio que tenga y adjunte los cobros por cada uno.

Servicios Públicos o Municipales	Cantidad	Servicios Públicos o Municipales	Cantidad
Gas o Combustible	\$	Basura	\$
Electricidad	\$	Agua	\$
Teléfono	\$	Drenaje	\$
Instalación de Servicios Públicos y Municipales	\$	Otros (especifique)	\$

Si reclama la cantidad ordinaria permitida por servicios públicos y municipales, adjunte los cobros por gas, electricidad u otro combustible para calefacción.

3. ¿Le ayudó alguien que no es parte de su hogar para fines de estampillas para comida a pagar cualquiera de sus costos de vivienda o servicios públicos y municipales? SI ES ASÍ, complete la sección 3a, b y c a continuación.

☐ SÍ

a. Escriba el costo total por vivienda pagado por el hogar para fines de estampillas para comida: \$

c. Dé el nombre de cada persona que pagó cualquiera de los costos, y si pagaron costos de vivienda y/o servicios públicos y municipales.

b. Escriba el costo total de servicios públicos y municipales pagado por el hogar para fines de estampillas para comida: \$

**6 CAMBIOS DE GASTOS POR CUIDADO DE PERSONAS A SU CARGO**

¿Ha comenzado a pagar o ha habido un cambio en la cantidad pagada por el cuidado de un niño o adulto incapacitado para que alguien en el hogar pudiera ir a trabajar, a entrenamiento o a buscar trabajo?

☐ SÍ

SI ES ASÍ, complete la sección que sigue y adjunte un recibo.

¿Quién recibió el cuidado?	Costo del Cuidado	¿Quién recibió el cuidado?	Costo del Cuidado	¿Quién recibió el cuidado?	Costo del Cuidado	¿Quién recibió el cuidado?	Costo del Cuidado
1.		2.		3.		4.	

**7 PERSONAS QUE NO CALIFICAN/EXTRANJEROS INELEGIBLES**

¿Ha tenido cualquiera de los cambios en las secciones ① a ⑥ cualquier persona que viva en su casa que sea extranjera inelegible o que haya sido descalificada del Programa de Estampillas para Comida?

☐ SÍ

SI ES ASÍ, dé el nombre de la persona y la fecha del cambio, y explique cuál fue el cambio:

**8 OTROS CAMBIOS**

¿Tiene cualesquier otros cambios que reportar? SI ES ASÍ, explique cuáles son.

☐ SÍ**9 CAMBIOS TEMPORALES**

¿Espera que cualquiera de los cambios reportados en esta forma sean temporales? SI ES ASÍ, explique enseguida.

☐ SÍ**CERTIFICACIÓN**

- Entiendo que el no reportar información o el proporcionar información falsa puede ocasionar prosecución legal con sanciones de multa, encarcelamiento, o ambos. Las sanciones pueden resultar en descalificación del programa, multas hasta por \$10,000 dólares y encarcelamiento hasta por 5 años. Las sanciones de descalificación son 6 meses por la primera violación, 12 meses por la segunda violación, y descalificación permanente por la tercera violación.
- Entiendo que tengo solamente 10 días para notificarle a mi trabajador(a) los cambios que haya en las circunstancias de mi hogar.
- Entiendo que la información que he proporcionado va a ser verificada por personal del gobierno local, estatal, y federal.
- Entiendo que si no reporto un cambio y subsecuentemente recibo estampillas para comida a las cuales no tengo derecho, tendré que reembolsar dichos beneficios.
- Entiendo que tengo derecho a pedir una audiencia con el estado con respecto a cualquier acción tomada por el Departamento de Bienestar del Condado.
- Declaro que la información contenida en este reporte es verdadera y correcta.

Firma (Miembro del Hogar o Representante Autorizado)

Fecha

Firma (Testigo, si usted firmó con una X)

Fecha

SECCIÓN PARA USO DEL CONDADO

E.W. Initials

Date

**Form Instructions**  
(For the Eligibility Worker)

**FOOD STAMP HOUSEHOLD CHANGE REPORT**

**Purpose:**

The DFA 377.5 is completed by a nonmonthly reporting household and is used to report changes in household circumstances that occur within the certification period. The household completes only the section(s) pertaining to the change(s) it is reporting. It is not mandatory that the household use this form to report a change as changes may also be reported by telephone or personal contact. This form is provided to the household at the time of initial certification, recertification, and also whenever the household submits a completed DFA 377.5 to the CWD. The CWD must pay the postage for the household to mail in the report. The Eligibility Worker uses the reported information to compute any change in the household's eligibility or benefits.

NOTE: Nonmonthly reporting PAFS households meet their food stamp reporting requirements by reporting any changes on the CA 7.

**Preparation:**

Enter the following information on the top of the front page of the report before providing it to the household:

- Head of household's name and mailing address
- Worker
- Phone Number

Question	Manual Section	Information Requested	EW Action
County-Use Section	63-504.422		Verification must be obtained prior to the issuance of any increase in benefits as a result of the reported change. Document verification of income in the county-use section.
1A	63-300.5 63-503.3 63-504.422(b) 63-504.431 63-504.432 63-505.511	Income Changes	If the household's income changes by more than \$25 or the source of income changes, the household completes this section and section 1C. The household's total monthly income (before deductions) is used to compute the change. Be sure that all pay stubs or other income verification are provided.



Question	Manual Section	Information Requested	EW Action
2	63-300.51 63-403.21 63-505.512	Household Composition Changes	If there is a change in the household composition, the household completes this section. For all Yes answers, be sure that all information is provided.
2A	63-402 63-407.1 63-407.2 63-504.4 63-505.512		If someone has moved into the home, the CWD must determine if the person should be added to the household. Either the most recent application must be updated or a CA 8 must be completed by the household.
2B	63-402		If someone moved out of the home or died, adjust the household size and benefit level accordingly.
2C	63-402.133		If someone got married, determine if household composition is affected.
2D	63-102(e)(1) 63-407.1 63-407.2 63-409.112 63-502.33 63-502.35 63-503.312 63-505.222 63-505.521		If someone became disabled or recovered from a disability, determine if household composition, income eligibility and/or medical expense deduction eligibility are affected.
2E	63-102(e)(1) 63-402.15 63-407.1 63-407.2 63-409.112 63-502.33 63-502.35 63-503.312 63-505.521		If someone turned age 60, determine if household composition is affected, provide the household with a DFA 285-C and use the net income eligibility standard.
2F	63-402.2 63-402.7 63-404 63-503.442		If someone got a new Social Security Number, determine if household composition is affected.

Question	Manual Section	Information Requested	EW Action
3A	63-501.51 63-505.514	Resource Changes	If anyone in the household got a licensed vehicle, this section is completed. The CWD must determine if the vehicle is resource exempt, and, if not, determine its countable value.
3B	63-501.1 63-501.2 63-501.3 63-501.4 63-501.7 63-501.8 63-503.44 63-505.515  63-409.21 63-409.22		If the household's liquid resources reach or exceed \$2,000 (or \$3,000, if elderly), this section is completed.         NOTE: If Yes to either 3A or 3B, complete the resource eligibility test section of the budget worksheet.
4	63-102(e)(1) 63-300.517 63-502.33 63-503.25 63-505.511 63-505.53	Medical Expenses	If there is a change of \$25 in the household's medical costs for a household member who is elderly or disabled this section is completed.      If Yes, be sure that all information is provided. The household must attach bills for any expenses it lists. To be permitted as a deduction, increases in medical expenses must be reported in the month of billing or when the bill becomes due.
5A	63-505.513	Address/Phone Number Change	If the household's mailing address or phone number changed (whether or not the household moved), Sections 5A and Section 5C are completed.

Question	Manual Section	Information Requested	EW Action
5B	63-505.513	Address Change (Move)	If the household moved, Sections 5A, 5C and 5D are completed.
5C	63-401 63-505.513	New Address/ Phone Number	If the household answered Yes to 5A and/or 5B this section is completed. Check that the household's mailing address and/or residence are still in the county.
5D	63-300.515 63-502.516 63-502.2 63-502.35 63-502.353  63-502.36 63-503.25 63-505.45 63-505.513	Shelter Cost Changes	<p>A household which moves must report any resulting changes in shelter costs. If Yes to 5D, any changes should be reported in section 5D1 and/or 5D2.</p> <p>Verification of housing costs must be provided when they change. Verification of actual utility costs must be provided when they change as a result of a change in residence. Verification of entitlement to the standard utility allowance (SUA) is required when a household claiming the SUA moves.</p> <p>If Yes to 5D3 the household must provide actual utility costs <b>paid</b> by the food stamp household. The CWD must determine which information should be used for the deduction (SUA, prorated SUA, actual costs billed, actual costs paid) based upon a review of the sharing relationship.</p>
6	63-300.521 63-502.34 63-503.25 63-505.522		A household whose dependent care expenses change will complete this section. If Yes, check that all required information and verification is provided.

Question	Manual Section	Information Requested	EW Action
7	63-402.22 63-403.21 63-404.4 63-503.442 63-505.512 63-805	Other Changes Disqualified Individuals/ Ineligible Aliens	A household with individuals living in the home who have been disqualified or who are ineligible aliens must report changes for these individuals. The CWD must determine the effect of these changes on the household's eligibility or benefit level.
8	63-300.53 63-504.42 63-504.43 63-505.52	Other Changes	If the household has any other changes to report, this section is completed. If Yes, be sure that the changes are explained in the space provided.
9	63-504.42 63-504.43 63-505.531	Temporary Changes	The household should explain any changes which it expects to be temporary.
		Certification	Check that the form contains all necessary signatures and dates.

Form-Related Information

Revision of Form

1. Attachment F-1 provides an advance copy of the revised English language version of the DFA 440(4/86). Attachment F-2 provides a copy of the Spanish language version of the form. As stated previously, the DFA 440(SP)(4/86) is a new form that will not be reproduced or stocked by the state. Those counties requiring translations in languages other than Spanish should contact Jeannie Rodriguez, Manager, Language Services Unit, at 916-323-9562.
2. Additional modification of this form will be necessary because of new disability verification requirements also mandated by the Federal regulations previously mentioned above in Attachment C, Revision of Form. An implementation date for state regulations has not yet been proposed. Please monitor your stock levels of the DFA 440(4/86) accordingly.

Outline of Major Changes to the Form

The DFA 440(4/86) contains the following major changes from the prior (5/78) version:

1. The title of the form was revised from "Verification of Physical or Mental Capacity" to "Verification of Physical or Mental Disability" (Food Stamp Program)".
2. A "Case Name" box was added to the County Use Only section.
3. The opening narrative paragraph was revised to provide clearer more specific instructions to the medical source who will complete the form and to eliminate both the out-of-date manual reference citation section and other incorrect information.
4. The term "Other Medical Authority" was revised to "licensed or Certified Psychologist".
5. Check boxes were added to permit the physician or licensed or certified psychologist to indicate that the applicant "IS or IS NOT mentally and/or physically unfit for gainful employment..."
6. Narrative changes were made to the applicant's statement in Part 1.
7. A release of information authorization was added.

Attachment F  
(Continued)

Implementation

No specific implementation date is provided for the DFA 440(4/86) as it has a "Recommended" form designation. However, the counties are requested to stop using existing stock of the DFA 440(5/78) as soon as administratively possible as the DFA 440(5/78) contains out-of-date and/or incorrect information as noted above in Outline of Major Changes to the Form.

Ordering of Stock

Orders for the English language version of the DFA 440(4/86) may be ordered from the DSS warehouse, according to normal procedures.

# **VERIFICATION OF PHYSICAL OR MENTAL DISABILITY (FOOD STAMP PROGRAM)**

COUNTY USE ONLY	
APPLICANT NAME	CASE NAME
CASE NUMBER	DATE OF APPLICATION
CASE WORKER NUMBER	DISTRICT NUMBER

**INSTRUCTIONS TO THE PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST:** *The Food Stamp applicant named below claims to be unfit for employment. When completed, this report should provide the welfare department with an assessment of the applicant's ability to work.*

## **PART I. APPLICANT STATEMENT**

I, \_\_\_\_\_, declare that I am not able to work for the following reason(s):  
(List and describe the nature of your disability).

---



---

I further authorize the release of all information regarding my disability to the \_\_\_\_\_ County Welfare Department. This authorization is valid for one year. I may request a copy of this authorization.

**APPLICANT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**APPLICANT ADDRESS** (Number, Street, City, Zip) \_\_\_\_\_

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## **PART II. STATEMENT OF PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST**

NAME AND ADDRESS \_\_\_\_\_

SPECIALTY/TITLE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

In my professional opinion, \_\_\_\_\_ ☐ IS ☐ IS NOT  
mentally and/or physically unfit for gainful employment as a result of the following condition(s):

---



---

If the above named applicant is unable to work, please indicate how long you expect this inability to engage in gainful employment will continue:

☐ Permanently ☐ Up to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year  
☐ Other (explain) \_\_\_\_\_

SIGNATURE OF PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST \_\_\_\_\_ DATE \_\_\_\_\_

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COUNTY STAMP

PLEASE MAIL THIS STATEMENT WITHIN 20 DAYS TO:

Attachment F-2

**VERIFICACIÓN DE INCAPACIDAD  
FÍSICA O MENTAL****(PROGRAMA DE ESTAMPILLAS  
PARA COMIDA)**

SÓLO PARA USO DEL CONDADO	
APPLICANT NAME	CASE NAME
CASE NUMBER	DATE OF APPLICATION
CASE WORKER NUMBER	DISTRICT NUMBER

**INSTRUCCIONES AL MÉDICO O PSICÓLOGO CON LICENCIA O AUTORIZACIÓN:** *El solicitante de Estampillas para Comida que se menciona a continuación alega que está incapacitado para trabajar. Cuando ya esté completo, este reporte debe proporcionar al departamento de bienestar una evaluación de la capacidad del solicitante para trabajar.*

**PARTE I. DECLARACIÓN DEL SOLICITANTE**

Yo, \_\_\_\_\_, declaro que estoy incapacitado para trabajar por la(s) siguiente(s) razón(es): (Anote y describa la naturaleza de su incapacidad).

Además autorizo que se dé al Departamento de Bienestar del Condado de \_\_\_\_\_ toda la información referente a mi incapacidad. Esta autorización es válida por un año. Quiero que se me dé una copia de esta autorización.

**FIRMA DEL SOLICITANTE** \_\_\_\_\_ **FECHA** \_\_\_\_\_

**DIRECCIÓN DEL SOLICITANTE** (Número, Calle, Ciudad, Zona postal) \_\_\_\_\_

**PARTE II. DECLARACIÓN DEL MÉDICO O PSICÓLOGO CON LICENCIA O AUTORIZACIÓN**

NOMBRE Y DIRECCIÓN \_\_\_\_\_

ESPECIALIDAD TÍTULO \_\_\_\_\_

TELÉFONO \_\_\_\_\_

En mi opinión profesional, \_\_\_\_\_ ☐ ESTÁ ☐ NO ESTÁ  
incapacitado(a) mental y/o físicamente para conservar empleo remunerado como resultado de la siguiente condición(es):

Si el solicitante mencionado arriba no puede trabajar, por favor indique cuánto tiempo espera que continúe esta incapacidad para desempeñar empleo remunerado:

☐ Permanentemente ☐ Hasta 3 meses ☐ De 3 a 6 meses ☐ De 6 meses a 1 año  
☐ Otro (explique) \_\_\_\_\_

FIRMA DEL MÉDICO O PSICÓLOGO CON LICENCIA O AUTORIZACIÓN \_\_\_\_\_

FECHA \_\_\_\_\_

**POR FAVOR ENVÍE ESTA DECLARACIÓN DENTRO  
DE LOS SIGUIENTES 20 DÍAS A:**

SELLO DEL CONDADO



### Form-Related Information

#### Revision of Form

The proposed revisions of the CA 22(10/85) and the CA 72(10/84) that were announced at the April 1986 CWDA Forms Committee meeting have not been processed because the May 1 and June 1, 1986 regulations changes mandated only one change in sponsor regulations. The adjusted gross income deduction was increased from 82 percent to 80 percent effective for the May 1, 1986 allotments. However, the resource limit remains at \$1,500 and the June 1, 1986 offset regulations do not apply to a farm self-employment loss incurred by a sponsor.

Therefore, since necessary revisions are limited to one change each for the AFDC and FS Programs in the second and third columns of the County Use Only sections of both forms, the counties are requested to make the manual changes as outlined below in Modification of Current Stock.

#### Modification of Current Stock

CWDs shall use existing stock of the CA 22(10/85) and the CA 72(10/84) by making the following modifications to the County Use Only sections of both forms:

1. Revise item "K" in the second column, AFDC Sponsor/Sponsor's Spouse/Income Computation, to read "Number of sponsored aliens on AFDC".

NOTE: If the sponsor sponsors other aliens, then the income and resources deemed for each Program shall be divided by the number of such aliens receiving or applying for AFDC and/or Food Stamps respectively.

2. Revise the percentage calculation at "B" in the third column, "Food Stamp Computation - Deemed Income" to read: "Adjusted earned income (80% of A)".

NOTE: As long as the correct deemed income totals are determined, no error will be charged if the form is not modified to show "on AFDC" or "80% of A".

Form Instructions for the Eligibility Worker

At this time there are no changes to the eligibility worker form instructions for either the CA 22(10/85) or the CA 72(10/84).

Implementation

The increase in the adjusted gross earned income deduction was effective for determining May 1986 allotments as outlined in ACI 86-22.